COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

March 17, 2010

Rusty Symons
Preferred Community Homes - Milliken
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Milliken, provider #13G053

Dear Mr. Symons:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Milliken, which was conducted on March 11, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 29, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by March 29, 2010. If a request for informal dispute resolution is received after March 29, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

M. Williams

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Barbara Dern, QMRP Amy Petersen, QMRP Common abbreviations/symbols used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional IPP - Individual Program Plan S.O. - Sexual Offender WIC - Written Informed Consent	W 000	"Preparation and implementation of this plan of corrections does not constitute admission or agreement by Milliken Heights with the facts, findings, or other statements as alleged by the State agency dated March 11, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Milliken Heights-Preferred Community Homes specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, review of the facility's sexual offender treatment policy, record review, and interviews with individuals and staff, it was determined the facility failed to ensure individuals were offered the opportunity to participate in social, religious, and community integration activities for 2 of 2 individuals (Individual #1 and #2) admitted to the facility within the last one and a half months. This resulted in community integration opportunities being denied to the individuals. The findings include: 1. The facility's S.O. Treatment policy, dated	W 136	RECEIVED MAR 30 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsey Crews — TITLE: Administrator — (X6) DATE: 3/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 136	Continued From page 1 3/4/10, stated individuals would be on one-to-one staffing, arms length, and line of sight supervision while in the community. During an observation at the facility on 3/9/10 from 6:53 a.m. to 8:33 a.m., it was noted that individuals were talking about their evening plans. When asked, Individual #1 stated he was not allowed to go off the property during his first 30 days after being admitted to the facility. When asked, present staff stated all individuals newly admitted to the facility were only allowed to go to school, group counseling, and medical appointments during their first 30 days. Individual #1's IPP, dated 2/23/10, documented he was admitted to the facility on 1/27/2010. His record contained multiple documents including his IPP, dated 2/23/10, his WIC for Sexual Offender Treatment Restrictions, dated 1/28/10, his Sexual Offender Program Treatment Contract, dated 1/28/10, and his Initial Behavior Assessment, dated 2/25/10. None of these documents specified restrictions related to community integration opportunities. Further, Individual #2's Tentative Treatment Plan, dated 2/12/10, showed he was admitted to the facility on 2/13/10. His record contained multiple documents including his Tentative Treatment Plan, dated 2/12/10, his WIC for Sexual Offender Treatment Restrictions, dated 2/13/10, his Sexual Offender Treatment Program Contract, dated 2/13/10, and his Initial Behavior Assessment, dated 3/5/10. None of these documents specified restrictions related to community integration opportunities. When asked, the AQMRP stated during an	W 136	**W 136 483.420(a)(11) PROTECTION OF CLIENTS RIGHTS** The facility will ensure individuals are offered the opportunity to participate in social, religious, and community integration activities. The facilities S.O. Treatment policy does not identify a 30 day restriction on access to these types of activities. Effective 03/11/2010 all clients, regardless of time living in the situation were given access to these types of activities. Upon admission of any further clients no 30 day restrictions to said activities will be implemented. The facility Administrator and QMRP/AQMRP will ensure all treatment is in alignment with facilities S.O. Policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 136	Continued From page 2 interview on 3/11/10 from 11:45 a.m. - 1:45 p.m., she thought the restriction was identified in their S.O. Treatment Program Contract. The AQMRP stated individuals were restricted to the facility during the first 30 days of admission in order to assess the level of risk toward themselves and others. The facility failed to ensure that Individual #1 and Individual #2 were offered opportunities to participate in community integration activities.	W 136		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W136.	MM207	**MM 207 16.03.11.075.13 FREEDOM OF ASSOCIATION** Please Refer to W 136 RECEIVED MAR 30 2010 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/26/10